STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING _____ B. WING _____	C 11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	**2010 N CAPITOL AVE INDIANAPOLIS, IN 46202**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00157423, IN00157862, and IN00159167.

This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00156178.

Complaint IN00157423 - Unsubstantiated due to lack of evidence.

Complaint IN00157862 - Unsubstantiated due to lack of evidence.

Complaint IN00159167 - Unsubstantiated due to lack of evidence.

Survey dates: November 12, 13, 2014

Facility number: 000131
Provider number: 155226
AIM number: 100274910

Survey team:
Connie Landman RN-TC

Census bed type:
SNF/NF: 110
Total: 110

Census payor type:
Medicare: 14
Medicaid: 74
Other: 22
Total: 110

Sample: 7

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING _____ B. WING _____	C 11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	**2010 N CAPITOL AVE INDIANAPOLIS, IN 46202**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 North Capitol Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00157423, IN00157862, and IN00159167. Quality review completed 11/14/14 by Brenda Marshall, RN.	F 000		